
Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
Home Health Prospective Payment System
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The **Home Health Prospective Payment System (HH PPS)** was implemented on October 1, 2000 as mandated by the Balanced Budget Act of 1997 and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999.

Under the HH PPS consolidated billing requirement, Home Health Agencies (HHA) must bill for all of the following provided during the 60-day HH episode:

- Skilled nursing services;
- Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services;
- Routine and non-routine medical supplies;
- HH aide services; and
- Medical social services.

Durable medical equipment is excluded from the consolidated billing requirement and is paid on the fee schedule outside the HH PPS rate.

COVERAGE OF HOME HEALTH SERVICES

Medicare covers HH services when the following criteria are met:

- The beneficiary to whom the services are furnished is an eligible Medicare beneficiary who is not enrolled in a Medicare Advantage Plan;
- The HHA that furnishes the services has in effect a valid agreement to participate in the Medicare Program;
- The beneficiary qualifies for coverage of HH services;
- The services are a covered Medicare benefit;
- Medicare is the appropriate payer; and
- The services are not otherwise excluded from payment.

To qualify for the Medicare HH benefit, a beneficiary must:

- Be confined to the home;
- Be under the care of a physician;
- Be receiving services under a plan of care established and periodically reviewed by a physician; and
- Be in need of skilled nursing care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable), be in need of PT or SLP services, or have a continuing need for OT services.

A beneficiary's residence is wherever he or she makes his or her home (e.g., own dwelling, apartment, relative's home, home for the aged, or other type of institution). Hospitals, Skilled Nursing Facilities, and most nursing facilities under the Medicaid Program are not considered a beneficiary's residence under the HH benefit if they meet the requirements under Sections 1861(e)(1) or 1819 (a)(1) of the Social Security Act (the Act). The Act can be accessed at **http://www.ssa.gov/OP_Home/ssact/comp-ssa.htm** on the Web.

For a beneficiary to be considered confined to the home, leaving home requires a considerable and taxing effort. The beneficiary may be considered homebound if absences from the home are infrequent, for periods of relatively short duration, or for the need to receive health care treatment. In general, a beneficiary is considered homebound if leaving home is medically contraindicated or he or she has a condition due to an illness or injury that restricts the ability to leave the place of residence except with the aid or assistance of:

- A supportive device (e.g., crutches, cane, wheelchair, or walker);
- Special transportation; or
- Another person.

ELEMENTS OF THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

The elements of the HH PPS include the following:

- **Payment for the 60-day episode**—The unit of payment under the HH PPS is a 60-day episode of care. The HHA receives approximately half of the estimated case-mix and wage-adjusted payment for the full 60 days when the Regional Home Health Intermediary receives the Request

for Anticipated Payment (RAP) and the residual half at the close of the 60-day episode unless there is an applicable adjustment to that amount. The case-mix and wage-adjusted national 60-day episode payment is adjusted for case-mix based on the beneficiary's condition and care needs or case-mix assignment. The payment is also adjusted to account for area wage differences. Additional 60-day episodes can be initiated for longer-stay beneficiaries as long as the eligibility requirements are still met.

- **Case-mix adjustment**—After a physician prescribes a home care assessment, the HHA uses the Outcome and Assessment Information Set (OASIS) to assess the beneficiary's condition and the likely skilled nursing care, therapy, medical social services, and HH aide services that will be needed at the beginning of the episode of care. OASIS items that describe the beneficiary's condition and his or her PT, OT, and SLP services needs as well as whether a particular episode is considered to be early (first or second) or later (third or later) in the sequence of HH episodes are used to determine the case-mix adjustment to the national standardized 60-day episode payment rate. Currently, one hundred and fifty-three case-mix groups called Home Health Resource Groups (HHRG) as measured by the OASIS are available for classification. The assessment must also be completed for each subsequent episode of care a beneficiary receives.
- **Wage adjustment**—The HH PPS used wage adjustment factors that reflect the relevant level of wages and wage-related costs applicable to the furnishing of HH services and to provide appropriate adjustment to the episode payment to account for area wage differences. We apply the appropriate wage index to the labor portion of the HH PPS rate based on the geographic area where the beneficiary receives the HH services. Each HHA's labor market area is based on definitions of Metropolitan Statistical Areas issued by the Office of Management and Budget. For the HH PPS, we use the pre-floor and pre-reclassified hospital wage index to adjust the labor portion of the HH PPS rates based on the geographic area where the beneficiary receives the HH services. We believe the use of the pre-floor and pre-reclassified hospital wage index data results in the appropriate adjustment to the labor portion of the costs as required by statute.
- **Outlier payment**—The HH PPS allows for outlier payments to be made to providers, in addition to regular 60-day case-mix and wage-adjusted episode payments, for episodes with unusually large costs due to patient HH care needs. Outlier payments are made for episodes where the estimated costs exceed a threshold amount. The wage-adjusted outlier costs are imputed for each episode by applying the national standardized per-visit amounts to the number of visits by discipline (skilled nursing visits; PT, OT, and SLP services; medical social work; or HH aide services) reported on the claim. The wage-adjusted outlier threshold amount is computed by summing the case-mix and wage-adjusted episode payment amount and the wage-adjusted fixed dollar loss (FDL) amount (the national standardized 60-day episode payment amount multiplied by the FDL ratio, adjusted to account for area wage differences). The outlier payment is determined by subtracting the wage-adjusted outlier threshold amount from the wage-adjusted outlier costs, of which 80 percent (the loss-sharing ratio) is paid to the HHA as the outlier payment. The statute requires that if the Secretary of the Department of Health and Human Services (HHS) chooses to have an outlier policy, the estimated total outlier payments be no more than 5 percent of total estimated total HH PPS payments. According to law, in any given year, the Centers for Medicare & Medicaid Services (CMS) must not exceed 5 percent of estimated total HH PPS payments in outlier payments. From the inception of HH PPS through calendar year (CY) 2009, CMS managed the FDL amount and the loss-sharing ratio to target an outlier payment outlay of 5 percent of total estimated HH PPS payments. CMS reduced the HH PPS base rates by 5 percent to fund these outlier payments. In recent years excessive growth in outlier payments has occurred under the HH PPS, primarily the result of suspiciously

high outlier payments in targeted areas of the country, resulting in outlier payments above the 5 percent target. Although program integrity efforts associated with excessive outlier payments continue in targeted areas of the country, we continue to be at risk of exceeding the 5 percent statutory limit on estimated outlier expenditures. For CY 2010, CMS changed its outlier policy to ensure appropriate payments for outlier episodes while addressing some of the questionable growth in outlier expenditures in targeted areas such as Miami-Dade, Florida. Specifically, CMS imposed an agency aggregate outlier cap such that no more than 10 percent of an HHA's total payments will be paid as outlier payments. CMS also reduced the target for yearly outlier payment outlay from 5 percent of total estimated HH PPS payments to 2.5 percent, thus enabling CMS to return 2.5 percent to the HH PPS base rates. CMS also lowered the FDL ratio to from 0.89 to 0.67. CMS will continue to monitor outlier payments under the HH PPS to identify any unintended consequences this policy might have on HHAs or beneficiaries.

- **Adjustment for four or fewer visits**—A Low-Utilization Payment Adjustment (LUPA) is made for beneficiaries who require four or fewer visits during the 60-day episode. These episodes are paid the labor adjusted, national standardized, service-specific per-visit amount multiplied by the number of discipline-specific visits actually furnished during the episode. Beginning in CY 2008, for LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent episodes for a given beneficiary, there is an increase in payment to account for the front-loading of assessment costs and administrative costs. That amount was established at $87.93 for CY 2008 and has been updated by the HH market basket increases for CY 2009 and 2010. The current LUPA add-on amount for CY 2010 is $97.72.
- **Adjustment for change in condition**—Originally, when a beneficiary experienced significant change in condition (SCIC) during the 60-day episode that was not envisioned in the original physician's plan of care and case-mix adjustment, a SCIC adjustment occurred, which required the determination of a new payment amount. Beginning on January 1, 2008, the SCIC adjustment policy has been eliminated based on comments from the public and continued analysis of the policy.
- **Adjustment for transfer to another HHA or discharge and return to the same HHA**—A partial episode payment (PEP) adjustment is made when a beneficiary elects to transfer to another HHA or is discharged and readmitted to the same HHA during the 60-day episode. The discharge and return to the same HHA during the 60-day episode period is only recognized when a beneficiary reached the treatment goals in the original plan of care. The original plan of care must be terminated with no anticipated need for additional HH services for the balance of the 60-day period. The PEP adjustment is determined by proportionally adjusting the original 60-day episode payment to reflect the length of time the beneficiary remained under the HHA's care before the intervening event. The 60-day episode clock is restarted for the subsequent episode and a new plan of care and assessment is established. The HHA initially receives approximately one-half of the new HHRG payment (based on the RAP) and the final residual payment based on the final claim for that 60-day episode.

Per Section 5201 of the Deficit Reduction Act (DRA) of 2005, beginning in CY 2007 HHAs must submit the required quality data for the purposes of measuring health care quality. For HHAs that do not submit the quality data, as specified by the Secretary of HHS, the HH market basket percentage update is reduced by 2 percentage points. For CY 2010, HHAs that did not submit the required OASIS quality data during the time period after July 1, 2008 and before July 1, 2009 (the reporting requirement for CY 2010 payment) will be subject to a 2 percent reduction to the HH market basket percentage update (2.0 percent minus 2 percentage points or 0.0 percent). HHAs that submit quality data will receive the full HH market basket update of 2.0 percent for CY 2010. To find additional information about the DRA and reporting of HH quality data, visit **http://www.cms.hhs.gov/HomeHealthQualityInits/08_HHQIReportingforAPU.asp** on the CMS website.

To find additional information about the HH PPS, including the HH PPS Rate Update for CY 2010 Final Rule (CMS 1560-F) that was published on November 10, 2009, visit **http://www.cms.hhs.gov/HomeHealthPPS** on the CMS website.

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